Group Insurance Long Term Disability
Attending Physician's Statement

THIS FORM IS TO BE COMPLETED WITHOUT EXPENSE TO FWD LIFE INSURANCE COMPANY (BERMUDA) LIMITED

Name of Patient : _____ I.D. Card No. : _____

Employer's Name : _____ Occupation : _____

The above named is insured with FWD LIFE INSURANCE COMPANY (BERMUDA) LIMITED against the happening of certain contingent events associated with his/her health. A claim has been submitted in connection with Long Term Disability and, to enable us to assess the claim, we should be obliged if you would complete this statement.

In order for the claim to be valid, the following definition must be fulfilled :-

Partial Disability or Partially Disabled means as a result of the sickness or injury which caused total disability, the insured is:

1. able to perform one or more, but not all of the material and substantial duties of his own occupation on a full-time basis; or
2. able to perform all of the material and substantial duties of his own occupation on a part-time basis but not on a full-time basis.

Total Disability or Totally Disabled means during the waiting period and the next 24 months of disability the insured is:

1. unable to perform all of the material and substantial duties of his occupation on a full-time basis because of a disability:
   a. caused by injury or sickness;
   b. that started while insured under this policy: and
2. after 24 months of benefits have been paid, the insured is unable to perform with reasonable continuity all of the material and substantial duties of his own or any other occupation for which he is or becomes reasonably fitted by training, education, experience, age, physical and mental capacity.

1. Are you the patient's usual medical attendant?
   If yes, for how long and please give the patient's health history.
   _____
   _____

2. When were you first consulted for the disability and, at that time, how long had the symptoms been present ?
   _____

3. Has the patient previously suffered from the condition specified above or any related injury/illness ?
   _____

4. Please state briefly the cause of the disability ?
   _____

5. Was the disability due to injury/sickness arising out of the patient's occupation?
   _____

6. What is the nature and extent of the patient's condition at the first consultation ?
   _____

7. Please give you precise diagnosis and nature of treatment rendered by you.

_____

8. Please describe the symptoms currently disabling the patient ?

_____

_____

9. (a) Are stress, emotional or psychological condition relevant to the patient's disability ?
If yes, please comment.

_____

(a) Do you anticipate that any psychological condition will permanently affect the insured's ability to resume work? If yes, please comment.

_____

10. What is the patient's prognosis?

(a) When did the patient first absent from work due to the disability ?

_____

(b) Is the patient now totally disabled? If yes, for how long?

_____

(c) If not, what duties of the patient's job is he/she incapable of performing.

_____

_____

(b) When will the patient recover sufficiently to return to his/her usual occupation?

_____

11. Please provide the names and addresses of any hospitals confined and physicians consulted for the relevant injury/illness? (We would be grateful for copies of any relevant hospital reports that are available)

_____

_____

12. If there is any information which, in your opinion, will assist us in assessing the claim, please furnish such information below.

_____

Name of Attending Physician / Specialist (with qualifications	Address :
Signature of Attending Physician / Specialist	Telephone
	Date